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B&D ID
73702

PROJECT DESCRIPTION

Expansion or Enhancement Grant—Enhancement

Program Area Affiliation—Co-Occurring and Criminal Justice

Congressional District and Congressperson—New York 7, 16, 17, and 18; Joseph Crowley, José E. Serrano, Eliot L. Engel, and Nita M. Lowey, respectively

Public Health Region—II

Purpose, Goals, and Objectives—The overall purpose of the Bronx Mental Health Court Diversion Services is to reduce the cycle of drug use, decompensation, and incarceration of the dually diagnosed, mentally ill, substance-abusing population. The primary goal of the program is to enhance the best practices models of Treatment Alternatives to Street Crime (TASC) case management, combined with specialized court diversion. The program objectives involve screening, diagnosis, case management, treatment, housing, collaboration, and building linkages to integrated mental health and substance abuse services. (abstract; pages 10–11)

Target Population—The population to be served by this project is mentally ill chemically addicted (MICA) individuals residing in Bronx County. (abstract; pages 8–10)

Geographic Service Area—Individuals residing in Bronx County who appear in the Bronx County Supreme Court for a nonviolent felony or first-time predicate offending and who are eligible for the Mental Health Court Diversion Service. (abstract; pages 8–10)

Drugs Addressed—Alcohol and all other illegal substances. (abstract; page 13)

Theoretical Model—The theoretical model to be used is based on the best practices models of TASC case management and treatment for a comprehensive court diversion program. The program design is based on a hybrid model of comprehensive, community case management with a specialized court processing, mandate, and monitoring. The program is also built on the findings of the Substance Abuse and Mental Health Services Administration (SAMHSA) consensus-building grant Comprehensive Court-Based Diversion Project for Dually Diagnosed Mentally Ill Substance Abusing Individuals. (abstract; pages 6–7, 10–11, 15)

Type of Applicant—County

SERVICE PROVIDER STRUCTURE

Service Organizational Structure—The Bronx District Attorney's (DA) office will serve as the lead agency for the project. The Bronx DA will collaborate with the Bronx TASC program and other community treatment agencies. (abstract; pages 27–28)

Service Providers—TASC will be responsible for screening, diagnosing, placing, case managing, and monitoring participants. The Bronx DA will enhance its Drug Treatment Alternative to Prisons (DTAP) program for incarcerated substance abusers by adding the

proposed program as an alternative to the incarceration component to serve individuals with co-occurring mental health and substance abuse disorders. Community-based residential programs have agreed to accept program participants based on availability of beds. (abstract; pages 12–14, 18, 26)

Services Provided—The proposed program will operate similarly to the current substance abuse court diversion program. However, it will add a multidisciplinary team that includes mental health staff specially trained to recognize, diagnose, place, and monitor individuals with co-occurring mental illness and substance abuse. Specific program components include identification of participants, mental health screening and assessment, treatment plan, housing, case management and monitoring, and, on an as-needed basis, crisis support services. Specific treatment will include counseling, family support services, independent living skills training, AIDS counseling, vocational training and assistance with employment, relapse prevention, and physical and mental health services. (pages 6–7, 12–14)

Service Setting—Community-based residential programs have agreed to accept program participants based on availability of beds. (abstract; pages 12–14, 18, 26)

Number of Persons Served—The project will service 100 clients in the first year and 150 each in Years 2 and 3. (abstract)

Desired Project Outputs—The desired outputs are detailed in the goals and objectives described earlier. In summary, these include the expansion of treatment capacity for dually diagnosed mentally ill substance abusing individuals involved in the criminal justice system. (pages 10–11)

Consumer Involvement—Approximately 65 consumers and family members participate on the consensus panel, which also includes stakeholders, advocates, service providers, researchers, policymakers, and criminal justice representatives. The consensus panel was developed to assist the Bronx DA in enhanced program development. The consensus panel assisted in identifying the specific needs of the target population, leading to the development of the enhanced program. The former consensus panel is now the implementation planning committee for the program. (page 6)

EVALUATION

Strategy and Design—The program evaluation involves both a process and a formative evaluation. A longitudinal quasi-experimental design using repeated measures will be employed. The longitudinal design allows for evaluation at four different periods of time during program implementation. A matched-pairs design of the target population in the same geographical area, measuring the same constructs with similar or identical measurement, will be employed for three of the four time frames proposed. Data will be collected at baseline and 3-month, 6-month, and 12-month follow-up. (pages 18–21)

Evaluation Goals/Desired Results—The primary goals of the evaluation are to assess the quality and quantity of program implementation and fidelity and to examine program effectiveness. The desired results are to increase accessibility of treatment services and to reduce substance abuse and mental health problems among participants under the supervision of the criminal justice system. (page 20)

Evaluation Questions and Variables—The process evaluation will assess the quality and

quantity of integrated MICA and other services, examining both client- and program-level data. Court mandate, client needs, and appropriate services offered will be measured. Client demographics and history (criminal justice, family, mental health, substance use, and treatment history) will be collected, and social support, stressful life events/traumas, perceptions of likelihood of severity of criminal justice sanctions, quality of case management, type of services offered, length of wait time, number of participants, completion status, linkages to services, and barriers to services also will be examined. Program outcomes will measure variables such as criminal recidivism; frequency of substance use; readiness for treatment; psychiatric hospitalization; psychiatric status; violence; perceived coercion; functional status; health status; homelessness; treatment and other service utilization; continuity of treatment; number of clients screened, recruited, and enrolled; client and staff diversity; reduction in jail time and time gap to treatment; legal disposition; length and frequency of monitoring protocols; use of sanctions; number of MICA peers trained; number of designated beds; range and type of services; trainings for staff; and family and consumer satisfaction. (pages 18–24)

Instruments and Data Management—The background survey at initial intake will collect client demographics; history of mental health, substance abuse, and involvement in the criminal justice system; and motivation for program involvement, and assess barriers to program implementation. The mental health, substance use, and criminal justice attitude survey measures client beliefs. The change readiness assessment will measure collaborative change processes. The cultural competency measure is used to assess program content for cultural competency. Ethnographic interviews will be used to poll stakeholders on the collaborative consensus process and to measure fidelity to the program model. The following instruments are used in the formative evaluation: the GPRA tool; ASI; TCU drug screen; Use Disorders Identification Test; Quality of Life Instrument; PDQ-4+ Borderline Personality Disorder Scale; Iowa Personality Disorder Screen; General Symptoms Index; Brief Psychiatric Rating Scale; Trauma: Childhood Trauma Questionnaire; Post-traumatic Check List; Insight: The MacArthur Admission Experience Survey; MacArthur Community Violence Instrument; Psychopathy Check List; HCR-20 Risk Assessment; MacArthur Coercion Scale; Duke Social Support; MHSIP Consumer-Oriented MH Report Card; Treatment Experience Service Utilization Survey; and Self-Report Services Use. Interviews will be conducted to determine employability status. A mixed-method approach will be used for the process and outcome evaluation. Surveys, standardized evaluation instruments, program records, focus groups, interviews, and observations will all be employed. Simple, descriptive, nonparametric, and correlational statistics will be employed, and logistic regression and hierarchical regression models will be analyzed. (pages 18–22)